



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-866-247-1443 or visit [www.ebms.com](http://www.ebms.com). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call 1-866-487-2365 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	\$250 per covered person or \$750 per family unit. Each <b>JANUARY</b> a new <u>deductible</u> amount is required.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your deductible?</b>	Yes. Air ambulance, BridgeHealth or <i>miChoice</i> Surgery Benefit, Teladoc physician consultations, and the following preferred provider services: <u>prescription drug coverage</u> , and <u>preventive care</u> , are covered before you meet your <u>deductible</u> . <u>Copayments</u> do not apply to the <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	Yes. \$500 per inpatient admission, limited to two <u>deductibles</u> per person per calendar year; and \$500 per non-medical emergency room visit. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
<b>What is the out-of-pocket limit for this plan?</b>	<b>Medical coinsurance maximum out-of-pocket:</b> <u>Preferred Providers</u> : \$2,000 per covered person / \$6,000 per family unit. <u>Non-Preferred Providers</u> : Unlimited. <b>Super global maximum out-of-pocket</b> (is the most a member will pay in a calendar year for <u>deductibles</u> , <u>copayments</u> and <u>coinsurance</u> ): <u>Preferred Providers</u> : \$8,150 per covered person / \$16,300 per family unit; <u>Non-Preferred Providers</u> : Unlimited.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the out-of-pocket limit?</b>	<u>Deductibles</u> and <u>prescription drug copayments/coinsurance</u> are not included in the medical <u>coinsurance maximum out-of-pocket limit</u> . Non-preferred provider or facility penalty, Vision Service Plan benefits, <u>prescription drug</u> discounts or coupons, any difference between the private and semi-private room rate when a semi-private room is available, <u>premiums</u> , <u>balance-billing</u> charges (unless balanced billing is prohibited), and health care this <u>plan</u> doesn't cover are not included in the medical <u>coinsurance maximum out-of-pocket limit</u> or super global maximum out-of-pocket limit.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

<p><b>Will you pay less if you use a <u>network provider</u>?</b></p>	<p>Yes. Refer to your EBMS/Public Education Health Trust identification card, or login to <a href="http://www.ebms.com">www.ebms.com</a> or call 1-866-247-1443 for a list of <u>network providers</u>.</p>	<p>This <u>plan</u> uses a provider <u>network</u>. You will pay less if you use a <u>provider</u> in the <u>plan's network</u>. You will pay the most if you use an <u>out-of-network provider</u>, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.</p>
<p><b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b></p>	<p>No.</p>	<p>You can see the <u>specialist</u> you choose without a <u>referral</u>.</p>



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare	Limited to 20 visits/calendar year for massage therapy. Limited to 20 visits/calendar year for spinal manipulation/ chiropractic services.
	<u>Specialist</u> visit	20% <u>coinsurance</u>	0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare	
	<u>Preventive care/screening/immunization</u>	No charge	0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare	Pre-notification is recommended.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.optumrx.com/myOptumRx">www.optumrx.com/myOptumRx</a> or call 1-855-395-2022.	Generic drugs or Compound drugs	25% (\$10 min/\$25 max) <u>copayment/coinsurance</u> per prescription (34-day retail supply)		<u>Deductible</u> does not apply. If a covered person requests a brand name drug when a generic equivalent is available, they are responsible for the brand name drug <u>copayment/coinsurance</u> plus the difference in cost between the brand name drug and the generic drug.
		25% (\$20 min/\$55 max) <u>copayment/coinsurance</u> per prescription (35 to 90-day retail or mail order supply)		
	Preferred brand name drugs	25% (\$20 min/\$40 max) <u>copayment/coinsurance</u> per prescription (34-day retail supply)		
		25% (\$40 min/\$80 max) <u>copayment/coinsurance</u> per prescription (35 to 90-day retail or mail order supply)		
	Non-preferred brand name drugs	25% (\$45 min/\$85 max) <u>copayment/coinsurance</u> per prescription (34-day retail supply)		
		25% (\$90 min/\$170 max) <u>copayment/coinsurance</u> per prescription (35 to 90-day retail or mail order supply)		
	<u>Specialty drugs</u> - Value (Tier 1) - <u>Formulary</u> (Tier 2) - <u>Non-formulary</u> (Tier 3)	50% <u>copayment/coinsurance</u> up to \$100 per prescription 50% <u>copayment/coinsurance</u> up to \$400 per prescription 50% <u>copayment/coinsurance</u> up to \$600 per prescription		<u>Deductible</u> does not apply. <u>Specialty drugs</u> are limited to a 30-day supply per prescription.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare	Pre-notification is recommended.
	Physician/surgeon fees	20% <u>coinsurance</u>	0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare	None
<b>If you need immediate medical attention</b>	<u>Emergency room care</u> - Medical Emergency - Non-medical Emergency	20% <u>coinsurance</u>		Limited to services from the nearest hospital where professional and necessary treatment can be provided due to a Medical Emergency. The emergency room <u>deductible</u> is waived for medical emergency, accidental injury, or if admitted as an inpatient.
		20% <u>coinsurance</u> after medical <u>deductible</u> and \$500/visit emergency room <u>deductible</u>	0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare after overall <u>deductible</u> and \$500/visit emergency room <u>deductible</u>	
	<u>Emergency medical transportation</u> - Ground ambulance - Air ambulance	20% <u>coinsurance</u>		0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare; <u>deductible</u> does not apply

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
	<u>Urgent care</u>	20% <u>coinsurance</u>	0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <u>coinsurance</u> after overall <u>deductible</u> and \$500/admission inpatient <u>deductible</u>	0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare after overall <u>deductible</u> and \$500/admission inpatient <u>deductible</u>	Pre-notification is recommended. The inpatient deductible will only be applied twice/calendar year per covered person. Coverage limited to the semi-private room rate.
	Physician/surgeon fees	20% <u>coinsurance</u>	0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	20% <u>coinsurance</u>	0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare	None
	Inpatient services	20% <u>coinsurance</u> after overall <u>deductible</u> and \$500/admission inpatient <u>deductible</u>	0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare after overall <u>deductible</u> and \$500/admission inpatient <u>deductible</u>	Pre-notification is recommended. The inpatient deductible will only be applied twice/calendar year per covered person.
<b>If you are pregnant</b>	Office visits	20% <u>coinsurance</u>	0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g. ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare	
	Childbirth/delivery facility services	20% <u>coinsurance</u> after overall <u>deductible</u> and \$500/admission inpatient <u>deductible</u>	0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare after overall <u>deductible</u> and \$500/admission inpatient <u>deductible</u>	The inpatient deductible will only be applied twice/calendar year covered per person.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare	Pre-notification is recommended.
	<u>Rehabilitation services</u>	<u>Outpatient:</u> 20% <u>coinsurance</u>	<u>Outpatient:</u> 0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare <u>Inpatient:</u> 0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare after overall <u>deductible</u> and \$500/admission inpatient <u>deductible</u>	Pre-notification is recommended. The inpatient <u>deductible</u> will only be applied twice/calendar year per covered person. <b>Inpatient</b> is limited to 180 combined days/calendar year for Inpatient Rehabilitation Therapy and Skilled Nursing Facility and subject to the semi-private room rate. <b>Outpatient</b> includes speech, physical, and occupational therapies. Physical and occupational therapies are limited to 20 visits per therapy/calendar year.
	<u>Habilitation services</u>	<u>Inpatient:</u> 20% <u>coinsurance</u> after overall <u>deductible</u> and \$500/admission inpatient <u>deductible</u>	0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare after overall <u>deductible</u> and \$500/admission inpatient <u>deductible</u>	Pre-notification is recommended. The inpatient <u>deductible</u> will only be applied twice/calendar year per covered person. Limited to 180 combined days/calendar year for Inpatient Rehabilitation Therapy and Skilled Nursing Facility and subject to the semi-private room rate.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u> after overall <u>deductible</u> and \$500/admission inpatient <u>deductible</u>	0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare after overall <u>deductible</u> and \$500/admission inpatient <u>deductible</u>	Pre-notification is recommended. The inpatient <u>deductible</u> will only be applied twice/calendar year per covered person. Limited to 180 combined days/calendar year for Inpatient Rehabilitation Therapy and Skilled Nursing Facility and subject to the semi-private room rate.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>		Pre-notification is recommended for DME expenses over \$2,000.
	<u>Hospice services</u>	20% <u>coinsurance</u>	0% <u>coinsurance</u> up to the allowed amount; 125% of Medicare	Pre-notification is recommended.
If your child needs dental or eye care	Children's eye exam	\$25 <u>copayment</u>	Up to \$50	PEHT has contracted with Vision Service Plan (VSP) to provide vision care services; vision expenses do not apply to the medical <u>deductible</u> or <u>maximum out-of-pocket amounts</u> .
	Children's glasses	\$25 <u>copayment</u>	Up to \$70 for frame Up to \$50 for single vision lenses Up to \$75 for lined bifocal lenses Up to \$75 for progressive lenses Up to \$100 for lined trifocal lenses	Limited to one exam/calendar year and to one pair of lenses/calendar year and one frame every other calendar year.
	Children's dental check-up	Not covered		Dental benefits may be available as a separate election.

**Excluded Services & Other Covered Services:**

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Cosmetic Surgery
- Dental Care (Adult)
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Weight Loss Programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Hearing Aids
- Routine eye care (Adult) through VSP
- Routine Foot Care

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. For more information, **contact EBMS at 1-800-777-3575** or these agencies: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/agencies/ebsa/](http://www.dol.gov/agencies/ebsa/) or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: EBMS at 1-800-777-3575 or the DOL's Employee Benefits Security Administration at 1-866-444-EBSA (3272). Additionally, a consumer assistance program can help you file your appeal. Contact your state's program if available at: <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/>.

**Does this plan provide Minimum Essential Coverage? Yes.**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet Minimum Value Standards? Yes.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al **1-866-247-1443**.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog **1-866-247-1443**.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 **1-866-247-1443**.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' **1-866-247-1443**.

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)	Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	Mia's Simple Fracture (in-network emergency room visit and follow up care)
<ul style="list-style-type: none"> <li>■ The <u>plan's</u> overall <u>deductible</u> \$250</li> <li>■ <u>Specialist coinsurance</u> 20%</li> <li>■ Hospital (facility) <u>coinsurance</u> 20%</li> <li>■ Other <u>coinsurance</u> 20%</li> </ul>	<ul style="list-style-type: none"> <li>■ The <u>plan's</u> overall <u>deductible</u> \$250</li> <li>■ <u>Primary care physician coinsurance</u> 20%</li> <li>■ Hospital (facility) <u>coinsurance</u> 20%</li> <li>■ Other <u>coinsurance</u> 20%</li> </ul>	<ul style="list-style-type: none"> <li>■ The <u>plan's</u> overall <u>deductible</u> \$250</li> <li>■ <u>Specialist coinsurance</u> 20%</li> <li>■ Hospital (facility) <u>coinsurance</u> 20%</li> <li>■ Other <u>coinsurance</u> 20%</li> </ul>
<p><b>This EXAMPLE event includes services like:</b>                      Specialist office visits (<i>prenatal care</i>)                      Childbirth/Delivery Professional Services                      Childbirth/Delivery Facility Services                      Diagnostic tests (<i>ultrasounds and blood work</i>)                      Specialist visit (<i>anesthesia</i>)</p>	<p><b>This EXAMPLE event includes services like:</b>                      Primary care physician office visits (<i>including disease education</i>)                      Diagnostic tests (<i>blood work</i>)                      Prescription drugs                      Durable medical equipment (<i>glucose meter</i>)</p>	<p><b>This EXAMPLE event includes services like:</b>                      Emergency room care (<i>including medical supplies</i>)                      Diagnostic test (<i>x-ray</i>)                      Durable medical equipment (<i>crutches</i>)                      Rehabilitation services (<i>physical therapy</i>)</p>
<b>Total Example Cost</b> \$12,800	<b>Total Example Cost</b> \$7,400	<b>Total Example Cost</b> \$1,900
<b>In this example, Peg would pay:</b>	<b>In this example, Joe would pay:</b>	<b>In this example, Mia would pay:</b>
<i>Cost Sharing</i>	<i>Cost Sharing</i>	<i>Cost Sharing</i>
Deductibles* \$750	Deductibles \$250	Deductibles* \$750
Copayments \$48	Copayments \$697	Copayments \$0
Coinsurance \$2,520	Coinsurance \$585	Coinsurance \$230
<i>What isn't covered</i>	<i>What isn't covered</i>	<i>What isn't covered</i>
Limits or exclusions \$60	Limits or exclusions \$60	Limits or exclusions \$0
<b>The total Peg would pay is \$3,378</b>	<b>The total Joe would pay is \$1,592</b>	<b>The total Mia would pay is \$980</b>

\*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.